

Kentucky Teachers' Retirement System (KTRS)
Request for Qualifications (RFQ)
Medicare Eligible Health Plan (MEHP)
Answers to Respondents' Questions
July 14, 2006

1. Attachment A-1 states that plan components must be the same and must match or exceed the 2006 plan design elements. This attachment also states that higher scores will be given to where these design elements are exceeded. Must all plan design enhancements apply equally to the Medicare Advantage PFFS and self-insured MEHP options or can enhancements apply to one option as long as the other option matches the 2006 plan design elements?

KTRS Answer: *All plan design elements must apply equally to the Medicare Advantage Private Fee For Service and the self-funded Medicare Eligible Health Plan.*

2. The RFQ does not include the existing self-funded KTRS Prescription Drug Plan. For informational purposes, would KTRS have an interest in seeing the Medicare Advantage PFFS plan priced with and without a prescription drug plan that matches or exceeds the existing coverage level?

KTRS Answer: *No.*

3. The RFP mentions the intent to conduct a passive and electronic enrollment. Please describe the medium KTRS would use to transmit the data elements required by the Centers for Medicare and Medicaid Services for enrollment of a beneficiary into a Medicare Advantage plan.

KTRS Answer: *The qualified and awarded bidder, if any, will be responsible for any electronic enrollment and eligibility submissions shared with the Centers for Medicare and Medicaid Services (CMS) in a method required by CMS and in a method compliant with HIPAA. KTRS will work with qualified and awarded bidder, if any, in sharing electronic enrollment and eligibility submissions from our database. Currently KTRS sends such data using the secure web interface known as https, which will continue to be KTRS' preferred methodology.*

4. Does passive enrollment entail transmission of KTRS files in an electronic format to the bidder? If so, what is the frequency? If not, please provide detail of the data transfer mechanism.

KTRS Answer: *Yes. The frequency will be monthly to coincide with KTRS' internal pension payroll procedures. The remainder is answered in three above.*

5. The RFQ mentions that approximately 2,000 retired teachers have waived coverage under the KTRS MEHP. What are the consequences of a retired teacher waiving coverage under the MEHP? Can they reenroll at a future date? If so, under what circumstances and at what date? Will the 2,000 current waivers be allowed to reenroll during the upcoming annual enrollment period?

KTRS Answer: *A retired teacher who waives coverage under the Medicare Eligible Health Plan does not receive any financial consequence or other consequence of any sort. A retired teacher who waives the Medicare Eligible Health Plan may enroll the first day of the month following a HIPAA qualifying event or annually during open enrollment, which will be from November 15th, 2006 through December 31st, 2006 for the effective enrollment date of January 01, 2007.*

6. Does the current self-insured MEHP plan include any individual and/or aggregate stop-loss coverage? If so, please provide a description of the type of stop-loss coverage in place.

KTRS Answer: *The current self-insured Medicare Eligible Health Plan does not include any individual and/or aggregate stop-loss coverage.*

7. Please describe the current arrangement for administering COBRA. Of the current services provided, please describe the level of COBRA administration that will be required under the RFQ.

KTRS Answer: *In the RFQ certification and in supplying the cost portion of this bid, the vendor shall bid assuming all responsibilities of COBRA administration, including the following:*

- 1. Distributing COBRA compliant initial notices.*
- 2. Distributing COBRA compliant election notices.*
- 3. Distributing any other required COBRA compliant notices.*
- 4. Processing COBRA applications upon receipt from Kentucky Teachers' Retirement System.*
- 5. Billing COBRA enrollees.*
- 6. Collecting COBRA premiums.*
- 7. Submitting COBRA premiums to Kentucky Teachers' Retirement System for self-insured plan.*
- 8. Compilation of monthly activity and payment status reports.*

It should be noted that the current self-funded Medicare Eligible Health Plan only averages three COBRA enrollees each year. Under the current arrangement for administering COBRA, Kentucky Teachers' Retirement System performs responsibility one and two above, and our current third party administrator is responsible for the remainder. Kentucky Teachers' Retirement System reserves the right to continue performing the first two responsibilities for the self-funded Medicare Eligible Health Plan in 2007.

8. Attachment A6 states that a subcontractor cannot be used in offering the two plan components except for smaller functions. Please provide additional information as to when a specialty subcontractor may or may not be used.

KTRS Answer: *Section 1.5 of the Request for Qualifications copied below is clear with examples of the smaller functions.*

1.5 JOINT BIDS AND USE OF SUBCONTRACTORS

A respondent may not join with any other related or non-related insurance carriers in responding to the insured Medicare Advantage plan and self-funded Medicare Eligible Health Plan components of this RFQ. The respondent must be able to provide both plan components required in this RFQ. If a respondent responds with the ability to provide only one of the plan components required in this RFQ, the respondent's proposal will not be considered.

Smaller functions within the two plan components such as subrogation or COBRA administration may be subcontracted at the discretion of any awarded bidder. Any planned or proposed use of subcontractors must be clearly documented in the bid, including the name of the subcontractor. The prime contractor shall be completely responsible for all contract services to be performed.

9. The RFQ states that the qualified bidder must provide TPA services for the approximately 1,428 plan participants without Parts A and B coverage under the traditional Medicare program. Please provide the split of these participants showing the number that do not have Parts A and B coverages and those that do not have Part A but do have Part B coverage.

KTRS Answer: *The census information detailing the 1,428 participants on the cd-rom represents participants without Part A of Medicare at the time that query was produced. KTRS has no way of confirming which participants have stopped paying their monthly Part B premium or have reinstated their Part B status, but based upon KTRS' work with Medicare Part D, our belief is that we have less than 200 participants without Part B of Medicare.*

10. Do you plan to allow your retirees to carry over any deductible and Out of Pocket expenses, which have been incurred during the period of 7/1/06-12/31/06?

KTRS Answer: *No. The RFQ and its attachments are very clear that the benefit year currently is and shall remain the calendar year.*

11. For clarification purposes, will the vendor draft, print and mail the SPD's for the Self-Funded Medicare Eligible Health Plan or does KTRS plan to continue performing this task?

KTRS Answer: *In the RFQ certification, and in supplying the cost portion of this bid, the vendor shall bid assuming ownership of drafting, printing, and mailing the Summary Plan Description for the self-funded Medicare Eligible Health Plan. The Summary Plan Description for both the Medicare Advantage Plan and the self-funded Medicare Eligible Health Plan, along with all communications with KTRS members, must be reviewed and approved by KTRS staff prior to any mailing to KTRS members. KTRS reserves the right to edit and amend any and all communications with its membership.*

Also, KTRS reserves the right to decide at a later date to produce its own Summary Plan Description for the self-funded Medicare Eligible Health Plan and will be entitled to a reduction of the per participant per month administrative fees if KTRS assumes such responsibility.

12. For clarification, page 20 of the RFQ indicates a total participant number for May 2006 of 19,340. On page 21, you cite that the census file contains 19,178 individuals.

KTRS Answer: *The census file containing the distinct count of 19,178 participants as of May 2006 shall take precedence. The table on page 20 of the RFQ details monthly participant counts generated from an internal KTRS report that represents a count of participants, but not a distinct count, and the difference from month to month is less than 1%.*

13. Throughout the RFQ, you reference “material change” Would you be able to further define “material”?

KTRS Answer: *KTRS requires that the 2006 plan design elements, participants’ out-of-pocket amounts, and access to providers accepting Medicare, will not adversely change for 2007. However, since the Medicare Advantage Private Fee For Service product may be customized, these plan provisions may be enhanced. KTRS senior management has resolved that minimal member disruption is the highest priority consideration, and will determine what constitutes a material change in fact or perception. If the KTRS Executive Secretary concludes that there is an actual or perceived material change from 2006 to 2007, this RFQ may be canceled. The materiality determination by the Executive Secretary shall be final and conclusive.*

14. Page 10 of the questionnaire asks if we have an assistance program. Please clarify what is meant by an assistance program.

KTRS Answer: *A retiree assistance program that would function in a similar fashion to an Employee Assistance Program (EAP). A retiree assistance program usually provides access to resources that can assist the retiree with behavioral health services, life management assistance including transition and retiree living support, and information on care giving support.*

15. A6.51 refers to an assistance program; please explain what services are anticipated.

KTRS Answer: *See above.*

16. Does compensation in Section III, 3.3.5 refer to the fees and premiums paid to the bidder? If not, how is compensation defined?

KTRS Answer: *The respondent must agree to the method of compensation found in Attachment A5 for the services described in Attachments A through A6.*

17. Page 23 of the RFQ requests a disruption analysis. Because the PFFS providers are not contracted with, the analysis as described may not be able to be produced. Are you open to an alternative analysis format?

KTRS Answer: Attachment A 1) d. copied below clearly states that KTRS understands that the Private Fee For Service provider structure is non-contractual. The disruption analysis on page 23 below acknowledges that if a respondent does not currently have providers that are paying claims under their existing Medicare Advantage Private Fee For Service plan, then the alternative is to provide a detailed explanation of the provider communication campaign and strategy that would take place prior to January 01, 2007 in the format prescribed below.

A 1) d. Since the Medicare Advantage Private Fee For Service solution is not network based, the awarded bidder must conduct a provider focused educational campaign. Ensure that participant disruption with providers of service is minimal with your Private Fee For Service platform that is consistent with our existing plan design. Perform aggressive provider communication campaign to necessary providers prior to January 2007. Especially, this campaign should reach out to the most highly utilized providers to verify that they understand and accept both Medicare and your Medicare Advantage Private Fee For Service programs. Every effort must be made to ensure comparability with the existing indemnity style physician and hospital access mechanism that KTRS participants currently enjoy. With a Private Fee For Service plan, Medicare renders capitated payments for administering a beneficiary's benefits. However, rather than building out an independent provider network, Private Fee For Service plans utilize traditional Medicare's participating physicians and provider payment rates. A Private Fee For Service plan is required to offer benefits that are at a minimum actuarially equivalent to the traditional Medicare program. Under special employer group waivers, the design of a Private Fee For Service plan can be enhanced to meet an individual plan sponsor's design objectives as long as the resulting plan meets Medicare's minimal coverage requirements. In your experience, with limited exception, confirm that most providers that accept Medicare assignment accept Medicare Advantage-Private Fee For Service since they are paid at the same Medicare reimbursement level. Complete the participant disruption analysis within this section of the RFQ.

Page 23 Provider Access/Participant Disruption Analysis

Included on the CD is a file named "Provider TIN Claims Summary Thru 03/31/2006Revised.xls" representing recorded claims by TIN for the twelve months ended 03/31/2006. The report is sorted by the highest number of unique claimants/patients visiting each unique provider number. According to our existing third party administrator, the first row of data with a zero TIN number and with the highest number of unique claimants represents payments made directly to the patient.

Please perform an analysis in Excel indicating which providers are currently paying claims under your existing Medicare Advantage Private Fee For Service plan. For those that are not, please provide a detailed explanation of the provider communication campaign and strategy that would take place prior to January 01, 2007. KTRS understands that a provider will be paid using the same Medicare fee schedule under the Medicare Advantage Private Fee For Service product as being used under traditional Medicare Parts A and B. Therefore, there is no financial disincentive for a provider that already accepts traditional Medicare. Given that disruption to the KTRS participants must be minimal, please structure your answer regarding provider communication strategy in three levels: (1) providers seeing 100 or greater than 100 unique claimants; (2) providers seeing between 10 and 99 unique claimants; and (3) providers seeing less than 10 unique claimants.

18. Is the current self-funded MEHP established as a group plan or an individual plan?

KTRS Answer: Group plan.

19. Is it the intent of KTRS to have the bidder share risk for the claims experience of the self-funded MEHP?

KTRS Answer: It is the intent of KTRS to bear all risk up to a \$7.3 million annual claims paid aggregate for the self-funded MEHP, after that full risk is transferred to an insurance policy.

20. Is the stop-loss coverage for the self-funded MEHP a mandatory component?

KTRS Answer: *Yes. However, KTRS reserves the right to award a contract with or without this stop/loss coverage based upon KTRS' cost/benefit/risk analysis. Page 22 of the RFQ and Attachment A5 respectively state:*

Given this information, KTRS will be requesting in the cost section, Attachment A5, of this RFQ that the third party administrator services for the self-funded Medicare Eligible Health Plan be quoted with and without stop loss coverage with an aggregate annual limit of \$7.3 million and no individual limits.

For the self-funded Medicare Eligible Health Plan, (bidder) must supply one simple transparent stop loss coverage per participant per month figure for an annual aggregate of \$7.3 million only. There is to be no individual stop loss limits.

21. Are participants' contributions to the cost of the program collected by KTRS through pension deduction? If not, please explain the collection process.

KTRS Answer: *Participants' contributions are collected mostly through pension check deduction or bank draft, but some are billed by KTRS.*

22. Would KTRS be open to revisiting their retiree healthcare strategy?

KTRS Answer: *KTRS is open to new strategies, but not as part of a response to this RFQ.*

23. As a retirement system, what is the main focus for KTRS?

KTRS Answer: *Foremost, KTRS is a pension plan. KTRS is an independent agency and instrumentality of the Commonwealth of Kentucky that was established July 1, 1940 on an actuarially funded basis. KTRS provides pension and medical benefits to the state's retired educators. KTRS serves approximately 72,000 active members, 4,000 inactive members, and 38,000 benefit recipients, with approximately half of those being Medicare eligible. The medical benefit was established in 1964 as a pay-as-you-go plan.*

24. For retirees who are not Medicare eligible, will they remain on the Kentucky Employees Health Plan?

KTRS Answer: *Yes.*

25. Has your current third party administrator been with KTRS for many years? And when was this service last placed for bid?

KTRS Answer: *Yes. An outside vendor performed a bid process in the early 1990s.*

26. Is the Medicare Advantage Private Fee For Service plan meant to be a full replacement?

KTRS Answer: *Yes, for all participants that are eligible.*

27. In response to this RFQ, would you like to look at individual Medicare Advantage plans as well?

KTRS Answer: *No, not as part of this RFQ. It is KTRS' understanding that the individual plans cannot be fully customized to match our existing plan design elements.*

28. What if the Medicare Advantage product produces no savings to KTRS after 2007?

KTRS Answer: *The RFQ is clear that our participants would be placed back into the self-funded Medicare Eligible Health Plan on January 01 following the year that KTRS determines this product to be no longer financially feasible.*

29. Describe the funding mechanisms for the KTRS medical insurance fund.

KTRS Answer: *The medical insurance funding formula after the 2004 General Assembly is 1.50% of active teachers payroll plus the ability to borrow up to 3.25% of retirement contributions if approved by the pension actuary plus adequate funding from the General Assembly to support the pay-as-you-go plan through the medical insurance fund stabilization contribution. In addition, the Governor has the ability to allocate surplus General Fund revenue to the Medical Insurance Fund and has done so for this fiscal year.*

30. For the 1428 participants without Part A of Medicare, describe the order of payment determination as it exists in 2006 and expected for 2007?

KTRS Answer: *In 2006, for the participants without Part A of Medicare, the KTRS Medicare Eligible Health Plan is the primary payer of claims that would have been covered by Medicare Part A and the secondary payer of claims for Medicare Part B. For Part A claims, payment is rendered to the provider calculated at 95% of the billed amount minus applicable deductibles and copayments then minus any amount Medicare Part B pays. The same is expected for 2007.*

31. Similar plan sponsors are supplying coverage that will out last the funding source via federally regulated standard Medigap plans on an individual basis. Would KTRS be open to this as a future retiree medical strategy?

KTRS Answer: *Not as part of this RFQ. It is KTRS' understanding that these individual plans cannot be fully customized to mirror our existing plan design elements.*

32. What is the KTRS Board of Trustees role and responsibilities with regard to the KTRS Medical Insurance Fund?

KTRS Answer: *KRS 161.675 (2) stipulates ... "The Board of Trustees may change the levels of coverage and eligibility conditions to meet the changing needs of the annuitants and when necessary to contain the expenses of the insurance program within the funds available to finance the insurance program."*

33. Please provide additional information on how the Part A benefits are currently adjudicated for the 1,428 participants without Part A of Medicare. Specifically, it would be helpful to know the following:

- ❑ Are the claims being administered twice? If so, is the initial payment to the provider and is it paying exactly like Medicare? If so, is the second payment applying the supplemental benefit wrap?

KTRS Answer: *No, for our participants without Part A of Medicare, the Part A benefit claims are not being administered twice. One payment is rendered to the provider calculated at 95% of the billed amount minus any amount Medicare Part B pays.*

- ❑ Is payment being limited to Medicare Fee Schedule or other fee schedule, or paying billed charges, with no U&C fee cut?

KTRS Answer: *Billed charges with no U&C fee cut.*

- ❑ What is the member's responsibility?

KTRS Answer: *The remaining 5% of covered Medicare Part A charges.*

34. CMS requires certain data elements to electronically enroll a member. Please indicate which of the following data elements KTRS could provide on the EDI for the PFFS members.

<u>Data Element</u>	<u>KTRS Answer:</u>
a) Medicare Claim Number (this is their CMS assigned member number)	<i>Yes. See footnote below.</i>
b) Medicare Part A effective date & Part B effective date	<i>Not currently captured on our main eligibility database, but is present in imaged file of Medicare card. See footnote below.</i>
c) Is the participant qualified as End Stage Renal?	<i>Not currently on our main eligibility database. See footnote below.</i>
d) Is the participant enrolled in Medicaid? If so, must include the participant's Medicaid member ID.	<i>Not currently on our main eligibility database. See footnote below.</i>
e) Does the participant reside in a Nursing Home? If so name of facility, address, phone.	<i>Yes, if participant has supplied this as part of their permanent residential information.</i>
f) Person to notify in case of emergency (name, relationship, phone).	<i>Not currently on our main eligibility database.</i>
g) If the participant is paying any portion of the premium-- need payment information--will we receive pertinent information (e.g. bank name, routing & account number, credit card information, etc.)?	<i>KTRS has banking information for the majority of our participants, but we will not be providing such. KTRS will be paying all monthly premiums and will use our already established pension deduction and billing methodologies for those retirees who contribute to their premium and those spouses that pay the full premium.</i>

Footnote: For a, b, c, and d above, KTRS' understanding is that the awarded MA organization, if any, will supply and maintain this information through their contractual relationship with CMS, which includes data sharing of pertinent Medicare elements on behalf of our group.

35. Question 4.2.2: “Contract, if awarded, will be written to allow KTRS to self-fund the Medicare Advantage plan component once feasible”. Are you stating that KTRS wants to revert this to an ASO account or that KTRS wants this to be a 100% employer contribution?

KTRS Answer: *KTRS does not want 100% employer contribution. KTRS’ true preference is to have a Medicare Advantage Private Fee For Service plan contracted with a Medicare Advantage organization that will structure the contract with KTRS as follows:*

- ❑ *KTRS pays the MA organization a per participant per month administrative fee for the services of the MA organization.*
- ❑ *MA organization submits all Medicare subsidies in excess of actual claims costs to KTRS.*

36. Question A6.9c: “Do you currently provide consulting services on Medicare strategies and future changes at the federal level including cost containment strategies?” Please clarify if you are looking for something specific.

KTRS Answer: *Please supply examples of how your organization has the knowledge to consult on future Medicare strategies and cost containment strategies and how your organization has applied this knowledge in assisting existing retirement systems with those strategies.*

37. For an MAPD product, we must abide by CMS guidelines. If the CMS guideline differs from something that you are requesting, would that put us out of the running?

KTRS Answer: *One of the bid components is for a MA product and not an MAPD. It is KTRS’ requirement that any awarded MA plan must abide by CMS guidelines as well. KTRS is not aware of any CMS guideline that conflicts with our RFQ, but if such conflict exists, then it will not “put you out of the running”.*